DISABILITY SCREENING FORM

FOR REFERRAL TO DIVISION OF VOCATIONAL REHABILITATION

NAME OF PARTICIPANT: _____

ADDRESS: _____

_____

PHONE: _____

SOC. SEC. #: _____

If the answer to any of these questions is "Yes", please explain in the space following the question.

1. Do you have any physical/medical problems? (Do you use a cane, have trouble walking, trouble with hands or arms, heart condition, etc.)

2. Do you notice any trouble hearing what is being said, particularly in a group?

3.Do you have trouble seeing print or seeing in the distance?

4. Did you receive special education or tutoring in high school or ever have an Individualized Education Plan (IEP)?

5. Do you have back trouble or trouble sitting for long periods of time?

6. Do you have constant or frequent pain?

7. Do you have trouble lifting heavy objects?

8. Do you have trouble reading, writing, or understanding directions or have you ever been told you have a learning disability?

9. Do you have trouble keeping your attention on a task or trouble making decisions or solving problems?

10. Have you ever lost a job due to drinking or using drugs or been charged with DWI?

11. Do you ever feel panicked about leaving the house?

12. Do you have periods of time when you feel unusually sad?

13. Do you have trouble controlling your anger?

14. Do you have trouble sleeping or feel that all you want to do is sleep?

15. Have you ever been told that you have depression or a mental health problem or have you seen a counselor for problem?

16. Do you think that you may have a disability or problem (including a problem with alcohol or drugs) that affects your ability to work?

I am interested in talking with a counselor from the Division of Vocational Rehabilitation to learn more about services I may be eligible for.

_____ _____

Participant signature Date

Worker making referral: _____

Agency: _____

Phone: _____